

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4211

CERTIFICATE OF DEATH

Reg. Dist. No.

04204

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL ALTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BEL ALTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>LOUISE</u> Last <u>ALBRITAIN</u>		4. DATE OF DEATH Month <u>4</u> Day <u>27</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 13, 1894</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>P. KEED WILLS</u>		14. MOTHER'S MAIDEN NAME <u>MARY LOUISE BOWLING</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-40-9569</u>	
17. INFORMANT <u>MRS. AUBREY GREEN, BEL ALTON, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) <u>Cerebral Hemorrhage 3-4-61</u> <u>Ins. were Sel - 2-3-56</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-4-61</u> <u>2-3-56</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-3-56</u> to <u>4-27-61</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4-27-61</u> , 19 <u>61</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>E. J. Edelen</u> M.D.			
PHYSICIAN'S NAME (Type) <u>E. J. EDELEN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-1-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Ignatius</u>		22d. LOCATION (City, town, or county) (State) <u>BEL ALTON, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>		24a. REC'D BY REGISTRAR <u>MAY 3 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>John S. Hearn</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12-5-29		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 170	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural		13. PLACE OF DEATH Baltimore, Md.		14. DATE OF DEATH 4-4-68		15. TIME OF DEATH 10:15 AM	
16. SIGNATURE OF PHYSICIAN J. Edgar Hoover		17. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		18. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		19. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		20. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
21. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		22. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		23. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		24. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		25. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
26. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		27. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		28. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		29. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		30. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
31. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		32. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		33. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		34. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		35. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
36. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		37. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		38. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		39. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		40. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
41. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		42. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		43. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		44. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		45. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
46. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		47. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		48. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		49. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		50. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
51. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		52. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		53. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		54. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		55. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
56. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		57. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		58. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		59. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		60. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
61. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		62. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		63. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		64. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		65. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
66. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		67. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		68. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		69. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		70. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
71. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		72. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		73. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		74. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		75. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
76. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		77. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		78. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		79. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		80. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
81. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		82. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		83. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		84. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		85. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
86. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		87. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		88. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		89. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		90. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
91. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		92. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		93. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		94. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		95. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
96. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		97. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		98. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		99. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		100. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	

(M)

(C)

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT

M

097

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
04205											
1. PLACE OF DEATH a. COUNTY Charles				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) La Plata				c. LENGTH OF STAY IN 1b D.O.A.				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Grayton (Rural)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Physicians Memorial Hosp.				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ALEAN Minnie Jackson COBEY				4. DATE OF DEATH Month 4 Day 17 Year 1961							
5. SEX F		6. COLOR OR RACE C		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 31, 1919		9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY At Home				11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anthony Giles				14. MOTHER'S MAIDEN NAME Estel Collins							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 450-38-1942		17. INFORMANT Mr. Eugene Cobey - Grayton, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 671X DUE TO HEMORRHAGE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Post PARTUM (c) RETAINED PLACENTA				INTERVAL BETWEEN ONSET AND DEATH 4-17-61 4-17-61 4-17-61							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DELIVERED AT HOME BY MIDWIFE											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE E. J. EDELEN M.D. EXAMINER'S NAME (Type) E. J. EDELEN DATE SIGNED 4/17/1961 Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4/21/1961		22c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		22d. LOCATION (City, town, or county) Grayton, Maryland			
23. FUNERAL DIRECTOR Archart Funeral Home, Inc.				24a. REC'D BY REGISTRAR APR 26 '61				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

04805

(M)

Hyphomys phaeus Sharp

(L)

1891

1892

1893

1894

1895

1896

1897

1898

1899

1900

1901

1902

1903

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

4213 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04206

Reg. Dist. No.

Item 7 Film G285 4/21/61 iwk

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY ST MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WALDORE RURAL		c. LENGTH OF STAY IN 1b MECHANICSVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY Lee DEMARR		4. DATE OF DEATH 4 12 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-31-31
9. AGE (In years last birthday) 30 yrs.		10. IF UNDER 1 YEAR: Months 4 Days 12 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Carr	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY DEMARR		14. MOTHER'S MAIDEN NAME Ruth TIPPETT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES 1942-44		16. SOCIAL SECURITY NO. 1-31-31	
17. INFORMANT MARY B DEMARR		Address MECHANICSVILLE MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 891-8 SHOCK DUE TO 20 and 30 burns of entire body except feet, due to explosion of gas tank by old wrecked car being demolished by heavy truck (b) SHOCK (c) SHOCK PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (If not related to the terminal disease condition given in Part I) SHOCK		INTERVAL BETWEEN ONSET AND DEATH 4-12-61 4-12-61	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 12 4 12 1961		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> 30	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. City or town (County) (State) MECHANICSVILLE MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. J. EDELEN		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) E. J. EDELEN		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4-12-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-17-61	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON		22d. LOCATION (City, town, or county) (State) ARLINGTON VA	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus		24a. REC'D BY REGISTRAR DATE APR 18 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

112106

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF
DEATH

NAME

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

CAUSE OF DEATH

MANNER OF DEATH

TIME OF DEATH

PLACE OF DEATH

ATTENDING PHYSICIAN

TESTIFYING PHYSICIAN

DEATH CERTIFICATE

DEATH RECORD

DEATH CERTIFICATE

DEATH RECORD

DEATH CERTIFICATE

DEATH RECORD

DEATH CERTIFICATE

DEATH RECORD

DEATH CERTIFICATE

DEATH RECORD

DEATH CERTIFICATE

DEATH RECORD

DEATH CERTIFICATE

DEATH RECORD

DEATH CERTIFICATE

DEATH RECORD

DEATH CERTIFICATE

DEATH RECORD

DEATH CERTIFICATE

DEATH RECORD

DEATH CERTIFICATE

DEATH RECORD

DEATH CERTIFICATE

DEATH RECORD

DEATH CERTIFICATE

DEATH RECORD

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4214

CERTIFICATE OF DEATH

Reg. Dist. No.

04207

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicans Memorial Hospital		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First (Ollie) Middle B. Last HAYDEN		4. DATE OF DEATH Month April Day 26 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 29, 1888
9. AGE (In years last birthday) yrs. 72		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Fishing	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Luke Hayden		14. MOTHER'S MAIDEN NAME Ada Simms	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-18-2320	
17. INFORMANT Mrs. Richard Robertson - Cobb Island, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cong. HT failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PARKINSON'S SYNDROME		INTERVAL BETWEEN ONSET AND DEATH 4-19-60 2-10-57	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased, from 2-10-57 to 4-19-61 , that I last saw the deceased alive on 4-2-61 , 19 61 , and that death occurred at 1 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) La Plata, Md. DATE SIGNED 4/27/1961			
ACTUAL SIGNATURE E. E. Edelen M.D.			
PHYSICIAN'S NAME (Type) F. J. EDELEN M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/29/1961	
22c. NAME OF CEMETERY OR CREMATORY Holy Ghost Cemetery		22d. LOCATION (City, town, or county) (State) Issue, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Archart Funeral Home, Inc. - La Plata, Maryland		24a. REC'D BY REGISTRAR MAY 2 '61	
24b. REGISTRAR'S SIGNATURE Clifton S. Thomas			

MEDICAL CERTIFICATION

(M)

(I)

099

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04208

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac Heights</u>		c. LENGTH OF STAY IN 1b <u>1 1/2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Potomac Heights</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>15 Glymont Road</u>				d. STREET ADDRESS <u>1 15 Glymont Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Sara</u> Middle <u>Catherine</u> Last <u>Pollak</u>				4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 25, 1919</u>	9. AGE (In years last birthday) <u>42</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Schiedam, Holland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>John Beart</u>				14. MOTHER'S MAIDEN NAME <u>(UNKNOWN)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>209-26-3723</u>		17. INFORMANT <u>John Pollak, 15 Glymont Rd., Potomac Heights, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drug Poisoning, Suicidal by use of</u> <u>9719</u> DUE TO <u>overdose of Tablets of Methedone and</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Capsules of Seconal</u> DUE TO <u></u> (b) <u></u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sworn 1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank G. Susan</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>April 21, 1961.</u>	
EXAMINER'S NAME (Type) <u>Frank A. Susan M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/24/1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Waldorf, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archart Funeral Home, Inc.</u>				24a. REC'D BY REGISTRAR <u>DATE APR 26 '61</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Knead</u>	

STATE OF TEXAS
DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of medical examiner	
10. Signature of physician		11. Signature of coroner		12. Signature of registrar	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of board of health		18. Signature of city or county	
19. Signature of state		20. Signature of federal		21. Signature of international	
22. Signature of other		23. Signature of other		24. Signature of other	
25. Signature of other		26. Signature of other		27. Signature of other	
28. Signature of other		29. Signature of other		30. Signature of other	
31. Signature of other		32. Signature of other		33. Signature of other	
34. Signature of other		35. Signature of other		36. Signature of other	
37. Signature of other		38. Signature of other		39. Signature of other	
40. Signature of other		41. Signature of other		42. Signature of other	
43. Signature of other		44. Signature of other		45. Signature of other	
46. Signature of other		47. Signature of other		48. Signature of other	
49. Signature of other		50. Signature of other		51. Signature of other	
52. Signature of other		53. Signature of other		54. Signature of other	
55. Signature of other		56. Signature of other		57. Signature of other	
58. Signature of other		59. Signature of other		60. Signature of other	
61. Signature of other		62. Signature of other		63. Signature of other	
64. Signature of other		65. Signature of other		66. Signature of other	
67. Signature of other		68. Signature of other		69. Signature of other	
70. Signature of other		71. Signature of other		72. Signature of other	
73. Signature of other		74. Signature of other		75. Signature of other	
76. Signature of other		77. Signature of other		78. Signature of other	
79. Signature of other		80. Signature of other		81. Signature of other	
82. Signature of other		83. Signature of other		84. Signature of other	
85. Signature of other		86. Signature of other		87. Signature of other	
88. Signature of other		89. Signature of other		90. Signature of other	
91. Signature of other		92. Signature of other		93. Signature of other	
94. Signature of other		95. Signature of other		96. Signature of other	
97. Signature of other		98. Signature of other		99. Signature of other	
100. Signature of other		101. Signature of other		102. Signature of other	

(M)

(1)

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
04209									
1. PLACE OF DEATH a. COUNTY Charles					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Charles				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) La Plata					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Doncaster (Rural)				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Physicans Memorial Hospital					d. STREET ADDRESS				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last Richard D. McCarthy Proctor					DATE OF DEATH Month Day Year 4-27 1961				
5. SEX Male					6. COLOR OR RACE Negro				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH November 22, 1902				
9. AGE (In years last birthday) 53 yrs.					IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor					10b. KIND OF BUSINESS OR INDUSTRY Unknown				
11. BIRTHPLACE (State or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Richard E. Proctor					14. MOTHER'S MAIDEN NAME Jennie E. Simmons				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No					16. SOCIAL SECURITY NO. 217-09-1920				
17. INFORMANT Alice Proctor - Doncaster, Maryland					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) CORONARY OCCLUSION, 4-27-61 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) D.O.A. ON ARRIVAL AT HOSP. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
DATE SIGNED 4/23/1961									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
22b. DATE THEREOF 4/30/1961									
22c. NAME OF CEMETERY OR CREMATORY Mt. Hope Church Cemetery									
22d. LOCATION (City, town, or country) (State) Doncaster, Maryland									
23. FUNERAL DIRECTOR Archart Funeral Home, Inc. - La Plata, Md.									
24a. REC'D BY REGISTRAR DATE MAY 2 '61									
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus									

1909

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1916

THE STATE OF NEW YORK



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4217

CERTIFICATE OF DEATH

Reg. Dist. No.

04210

1. PLACE OF DEATH o. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Indian Head</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u>				d. STREET ADDRESS <u>15 Poplar Lane</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>John Thaddeus Riley</u> First Middle Last				4. DATE OF DEATH <u>April 5 1961</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 14 1888</u>		9. AGE (In years last birthday) <u>73</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor, Train</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>William Riley</u>				14. MOTHER'S MAIDEN NAME <u>Rose Ennis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-30-1113</u>		17. INFORMANT <u>Mrs. Georgia J. Riley</u>		Address <u>Indian Head, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Cerebral Embolism</u> DUE TO (b) <u>Hypertensive Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>4 yrs</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4/4</u> , 19 <u>61</u> , to <u>4/5</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4/5</u> , 19 <u>61</u> , and that death occurred at <u>11:20</u> A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank A. Susan</u> M.D.				ADDRESS (Street, city or town, state) <u>5 Indian Head Ave</u> DATE SIGNED <u>4/6/61</u>			
PHYSICIAN'S NAME (Type) <u>Frank A. Susan M.D.</u>				<u>Indian Head, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-7-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Switzland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home, Waldorf, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>APR 10 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

131

NAME OF DECEASED [Handwritten: John Doe]		PLACE OF BIRTH [Handwritten: Baltimore, Md.]	
SEX [Handwritten: Male]		DATE OF BIRTH [Handwritten: Jan 1, 1900]	
OCCUPATION [Handwritten: Clerk]		CAUSE OF DEATH [Handwritten: Heart Disease]	
PLACE OF DEATH [Handwritten: Home]		DATE OF DEATH [Handwritten: Dec 15, 1945]	
TIME OF DEATH [Handwritten: 10:30 AM]		SIGNATURE OF PHYSICIAN [Handwritten: J. H. Smith]	
SIGNATURE OF REGISTRAR [Handwritten: M. J. Jones]		SIGNATURE OF WITNESS [Handwritten: A. B. White]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF NEXT OF KIN [Handwritten: Mrs. J. Doe]	
ADDRESS OF DECEASED [Handwritten: 123 Main St.]		ADDRESS OF NEXT OF KIN [Handwritten: 456 Oak St.]	
CITY [Handwritten: Baltimore]		COUNTY [Handwritten: Baltimore]	
STATE [Handwritten: Maryland]		ZIP CODE [Handwritten: 21201]	



This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his last illness. It should be filled out as soon as possible after death, and should be filed with the local health department.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4213

CERTIFICATE OF DEATH

Reg. Dist. No.

04211

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Point	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) THOMAS First A Middle D Last SHORTER		4. DATE OF DEATH Month 4 Day 10 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 26, 1877
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retirer	11. BIRTHPLACE (State or foreign country) Charles Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Shorter	
14. MOTHER'S MAIDEN NAME Elizabeth Long		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 216-07-5253		17. INFORMANT Mrs. Earl Hill- Rock Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.A. Lung 163 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3-60		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 , 19 60 , to 4 , 19 61 , that I last saw the deceased alive on 4-9 , 19 61 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE E. J. EDELEN		ADDRESS (Street, city or town, state) La Plata, Md. DATE SIGNED 4-11-61	
PHYSICIAN'S NAME (Type) E. J. EDELEN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/13/1961	
22c. NAME OF CEMETERY OR CREMATORY Holy Ghost Cemetery		22d. LOCATION (City, town, or county) (State) Issue, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Arehart Funeral Home, Inc. La Plata, Md.		24a. REC'D BY REGISTRAR APR 17 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

